May 21, 2019

Chairman Lloyd Doggett and
Members of the Subcommittee
Subcommittee on Health
Committee on Ways and Means
US House of Representatives
Washington, DC

Re: Statement on Protecting Patients from Surprise Medical Bills

Mr. Chairman and Members of the Subcommittee:

The following statement is submitted for inclusion in the record of the Hearing on Protecting Patients from Surprise Medical Bills, which is scheduled for May 21, 2019.

A. SUMMARY

FAIR Health recognizes the importance of addressing consumers' exposure to high healthcare bills for emergency care and in situations where they are faced with unexpected and unavoidable out-of-network services. We appreciate the concern and the efforts of the members of this Committee and are grateful for the opportunity to share our extensive experience with these consumer issues. In this statement, we outline FAIR Health's role in and experience with governmental healthcare policies and programs, including the New York State arbitration process; and then we describe three types of standards for healthcare fee reimbursements: providers' billed charges, in-network rates negotiated by providers and insurers, and Medicare rates.

1. About FAIR Health

FAIR Health is a national, independent nonprofit committed to providing all stakeholders in the healthcare sector with clear and actionable information about healthcare costs and insurance. FAIR Health was created in 2009 as part of the resolution of an investigation brought by the Office of the New York State Attorney General into certain perceived conflicts of interest associated with data utilized to support the adjudication of healthcare claims. Following its establishment, FAIR Health immediately became a national, trusted source of neutral and objective healthcare cost information.

The FAIR Health data repository contains over 28 billion claims from both fully insured and self-insured private insurance plans; it is adding over 2 billion new claims per year. The claims in the database constitute the records of plans covering over 150 million individuals, approximately 75 percent of the privately insured population of the country. Claims are contributed by approximately 60 insurers and claims administrators nationwide. FAIR Health benchmark products are used by plans that cover 190 million individuals throughout the country.

FAIR Health benchmarks cover all areas of healthcare nationwide—professional and facility inpatient and facility outpatient rates for specific services, procedures and equipment, all identified by the official codes for each type of service.

FAIR Health conducts all operations in-house with its own statistical, clinical, technology, policy, service and security experts. FAIR Health's capability to produce all of its products and analytics with its own staff facilitates consistency, accuracy and efficiency in its work.

FAIR Health's private claims data serve as the official data source for a variety of state health programs, including workers' compensation and personal injury protection (PIP) programs, as well as state consumer protection laws governing surprise out-of-network bills and emergency services. FAIR Health also has been requested to assist Medicaid programs with the sound administration of their claims. In addition, a number of federal agencies, including the Government Accountability Office (GAO), the Centers for Medicare & Medicaid Services (CMS), the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), and the White House, have consulted FAIR Health. Currently, FAIR Health data are among the resources used by the Bureau of Labor Statistics (BLS) in developing its medical price index.

Separately, FAIR Health holds extensive Medicare data. FAIR Health has been certified by CMS as a Qualified Entity (QE), and thus now has been entrusted with the complete collection of Parts A, B and D Medicare claims for the entire nation from 2013 to the present. FAIR Health also has worked with Medicaid programs on data collection improvements and quality initiatives.

Effectively, with its unparalleled private claims repository holding data representative of the populations in all 50 states and the District of Columbia, its comprehensive Medicare collection and its experience with Medicaid and other programs, FAIR Health already serves as the equivalent of a national All-Payer Claims Database (APCD).

2. FAIR Health Role in Surprise Bill Policy

FAIR Health has been consulted over the past four years by legislators, agency heads, and governors' and commissioners' offices in more than 20 states as well as by federal executive branch officials and members of Congress working to develop statutory and regulatory approaches to protect consumers from "surprise" emergency and out-of-network bills for healthcare services. A tax-exempt public charity, FAIR Health does not lobby nor does it take positions on the specifics of proposed policies; however, the organization believes its charitable mission includes sharing information based on its resources and experience with all parties. This statement reflects FAIR Health's experience assisting officials in formulating surprise billing solutions.

FAIR Health has provided officials with data resources and technical expertise with the complex and often nuanced issues posed by surprise bills. FAIR Health has informed officials and other stakeholders about the variations in values for billed charges, in-network rates and Medicare fees; the economic and policy features that cause structural and relational differences between governmental fee schedules and private healthcare and insurance market rates; and the varying effects of different approaches to independent dispute resolution (IDR).

Already a number of states, including, but not limited to, Arizona, California, Georgia, Kentucky, Pennsylvania and Wisconsin, reference FAIR Health healthcare cost benchmarks as guidelines or standards in a number of programs. FAIR Health also has served as the source of an official benchmark for various state surprise billing solutions. For example, Connecticut has adopted a law that mandates payment by the insurer at the highest of three specified standards. In New York, the state codified the term "Usual and Customary Cost" (UCC), which it defined as the 80th percentile charge from an independent database unaffiliated with any insurer. Rather than serving as a mandatory payment schedule or formula, UCC serves as a standard guideline for evaluation of billed charges and reimbursements in an IDR setting. The New York State Department of Financial Services designated FAIR Health's database as the sole independent source for the UCC benchmark standard.

3. New York: IDR with Required Considerations

Generally, consumer protection policies to counter high emergency and surprise bills have looked to standards such as billed charges, in-network rates or Medicare fees, sometimes as mandates and sometimes in conjunction with IDR. Recently, arbitration has received considerable attention. The New York consumer protection law, in particular, has been viewed by many as successful in reducing and resolving billing disputes. Since implementation, the New York approach has resulted in limited use of IDR (i.e., the parties apparently have resolved reimbursement issues absent the need for formal intervention) and, based on FAIR Health's studied evaluation of the data, has not contributed to increases in billed charges. While the success of the New York law has been touted by many, such commentary often fails to highlight the unique features of the law that likely contribute markedly to its success. For

example, the New York IDR process is often described as “baseball” arbitration. However, that shorthand description does not fully capture the thoughtful and nuanced decision-making process mandated under the law. Indeed, the New York law *requires* that the dispute resolution entity consider certain “relevant factors,” including the provider’s expertise, complexity of a case and the parties’ usual fees and reimbursements. Most importantly, the law requires that the determination of a “reasonable fee” include consideration of a specific benchmark standard for a fee for a particular service in the particular area based on an independent data source—i.e., the relevant UCC value as described above.

While New York defines UCC as the FAIR Health 80th percentile charge benchmark, the provision of a specific guideline, even more than the exact level of fee specified, encourages settlement of differences between what can be widely divergent offers by the parties. The dispute resolution entity is not required to mandate a fee at that benchmark level but can use that data point to help reach an equitable result. In addition, by referencing a benchmark from a neutral, non-conflicted source, the law avoids potential provider distrust of insurers’ representations of their internal rates and thereby avoids further provider challenges to insurer positions and eliminates any need to audit or otherwise regulate insurers’ participation in the process.

The selection of FAIR Health benchmarks to support these policies on surprise bills and other healthcare programs has been based on the organization’s independence, the breadth of its data, the objectivity of its methodology, the transparency of its processes and results and its lack of an agenda other than reliably representing the distribution of its benchmarks using recognized scientific statistical methodologies.

B. STANDARDS OF PAYMENT FOR HEALTHCARE SERVICES

In evaluating appropriate reimbursements for providers for out-of-network services in the context of surprise bill protections and other programs, legislators and regulators with whom FAIR Health has consulted generally have considered three different standards as the bases for such payments:

a. Providers’ charges (non-discounted fees) for a service in the relevant market, sometimes characterized as the usual, customary and reasonable rate or UCR;
b. Allowed amounts, which are the in-network fees paid under a plan to a provider for a service; or
c. Medicare fee schedule rates.

The use of objective, third-party standard rates, whether FAIR Health benchmarks or CMS rates, in establishing reimbursements for out-of-network emergency and surprise bills provides several advantages:

a. All parties have access to the same information.
b. It protects payors’ proprietary information relating to in-network rates.
c. It avoids potential provider distrust of payors’ reports of their rates and payors’ distrust of providers’ report of their fees.
d. It eliminates any need for audit/investigation of payors’ and providers’ practices.

1. Providers’ Charges

In a number of state programs, the payment standards for provider services are set according to charge benchmarks determined by FAIR Health on the basis of the recent, actual billed charges of providers in the particular geographic area where the service was rendered. FAIR Health charge benchmarks reflect the distribution of out-of-network billed charges for a particular service from the 5th to the 95th percentile in a specific geographic area.

Depending on the program, a percentile benchmark may be the prescribed payment or one of several standards. For example, Connecticut prescribes payment for out-of-network emergency services at the highest of three values: (1) the in-network rate (allowed amount) under the member’s plan; (2) UCR for out-of-network emergency services, with UCR set at the FAIR Health 80th percentile charge benchmark; or (3) the Medicare rate for the service. In New York State, the statute requires that arbitrators resolving healthcare fee disputes between payors and providers consider the FAIR Health 80th percentile charge benchmark for a service, among other factors. On the other hand, California law caps the fees that low-income individuals can be charged for emergency services at the FAIR Health 50th percentile “allowed” benchmark. (See the section below regarding “Allowed Amounts.”)

Because FAIR Health charge benchmarks are independent, based on 12 recent months of claims for actual charges in 493 local areas, they closely reflect the healthcare market economy in a particular area and time. In addition, the relationship between and among the percentile benchmarks for different procedures, as well as different medical specialties, corresponds to the relationships in the specific market. Accordingly, using percentile benchmarks facilitates flexibility in the level of a payment while still tying the overall system of payments to local market factors.

2. Allowed Amounts—"In-Network Rates"

Another basis for reimbursement standards is insurers' allowed amounts, i.e., their in-network rates of payment for specific services. FAIR Health provides percentile benchmark values from the 50th to the 95th percentile for imputed allowed amounts in 493 specific geographic areas based on 12 recent months of validated claims data. The statistical imputation methodology provides sound estimates of in-network rates without disclosing specific insurers' and providers' proprietary information. Although almost always lower than the charge benchmarks for the same services, the allowed amount benchmarks also reflect actual market dynamics. They indicate the range of payments negotiated between payors and providers in a specific area for specific services, and the differences in the benchmarks for the various specialists also correspond to the relationship of the payments made to different specialists for their services in the area.

3. Medicare Rates

Some programs employ the Medicare rate schedule as the standard for payment, using either the actual Medicare payment amounts in a particular region or a percentage of the Medicare rate, usually an amount higher than 100 percent of the Medicare rate. Although Medicare rates are accessible and easily adjustable by some percentage, they can present serious challenges when deployed in the general healthcare market.

As is widely known, Medicare was established to pertain to healthcare provided to the elderly, disabled and end-stage renal disease patients. Accordingly, Medicare is not designed to support the full range of medical services that necessarily include pregnancy, childbirth and pediatric care. Moreover, the Medicare fee schedule does not cover the full range of services as coded in the official American Medical Association CPT®[1] codes that federal regulation requires be used in billing and record-keeping. Even if the official Medicare schedule is adopted, the gaps in that schedule must be filled by other means.

Another complication is that Medicare rates are adjusted and readjusted, often annually, to promote specific federal policy goals and budget limitations; for example, to encourage primary care rather than certain specialized services. In addition, Medicare fees are subject to a ceiling—i.e., the amount of funds allocated for the program—which is not related to the market. In some cases, Medicare may pay less than cost. Accordingly, because of the special, nonmarket factors that affect Medicare rates, the use of Medicare rates as standards in the general healthcare market may require complex adjustments if different professionals are to be compensated fairly and providers' expenses in some high-cost markets are to be covered.

4. Alleviating Concerns about External Influences: Indexing

When policy makers consider establishing a specific standard for setting fees for emergency and surprise bills, stakeholders sometimes express concern—even if unwarranted—that the standard might be manipulated by external interested parties. For example, when the proposed standard is based on benchmarks for billed charges, payors have expressed concern that providers will increase prices inordinately to drive the benchmarks higher. On the other hand, when allowed benchmarks are considered as a standard, some providers have suggested that insurers and other payors will use hard bargaining tactics to drive in-network fees unduly low.

Although a review of charges since the adoption of a benchmark charge guideline in New York and a mandated charge benchmark in Connecticut reveal no unusual trends in billed charges, the fear or perception of possible manipulation can create a barrier to a solution and can be addressed. For example, a specific benchmark issued prior to enactment of legislation, whether charge or allowed, can be established as the standard for a year; in subsequent years, the benchmark values can be adjusted by a medical price index. After a reasonable period, say three to five years, the values can be reevaluated

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and updated, for example, by adopting a more recent base-year benchmark to recognize changes in treatment protocols, such as new medications or new technology that have increased or decreased the cost of providing a service.

C. FAIR HEALTH BENCHMARKS: METHODOLOGY AND SPECIFICITY

FAIR Health collects claims data from insurers and claims administrators throughout the country. From those data, FAIR Health produces two lines of percentile benchmark products. Its charge benchmarks are based directly on the distribution of actual, non-discounted fees for each service in a specific geographic area, provided there are a sufficient number of occurrences of the service in the area; for services with few occurrences, benchmarks are derived based on relative market values and local pricing. FAIR Health's allowed benchmarks are statistically imputed based on the actual amounts that insurers have negotiated with providers in their network as fees for services. Both product lines are based on the claims in the FAIR Health database and have been subjected to FAIR Health's extensive validation testing.

Data validation. FAIR Health has developed proprietary algorithms and methodologies for validating the data and determining benchmarks in consultation with academic experts in statistics, economics, public health and clinical care at major US universities. FAIR Health's processes include numerous quality tests to establish the accuracy and comprehensiveness of the data. In addition, claims are checked to confirm, for example, that they contain accurate zip codes, use proper procedure coding and report an appropriate number of units for each procedure, service, item or dosage.

Also, prior to determining its benchmarks, FAIR Health applies to the charge data an outlier methodology vetted by experts that identifies, and excludes from the data used in calculating benchmarks, those charges that are so extremely low or so extremely high that their inclusion would distort the distribution of charges represented by percentiles. In establishing its allowed benchmarks, FAIR Health applies a second outlier rule designed to keep the range of imputed allowed benchmarks within the distribution of the actual allowed amounts reported on claims for the particular service. FAIR Health bases its benchmarks on 12 consecutive months of data, for a period ending usually no more than 3 months before the release date of its modules. Charge benchmark modules and the allowed medical benchmark module are updated every six months, and the other allowed benchmark modules annually, with more recent data replacing earlier data.

Regions and percentiles. FAIR Health reports benchmarks for 493 geographic areas nationwide, called "geozips," that tend to track with the first three digits of a zip code. Accordingly, FAIR Health data reflect the granularity of the various medical markets. All benchmarks are determined exclusively on the basis of claims for services rendered in the particular geozip. FAIR Health does not determine, prescribe or recommend any specific benchmark as UCR. Rather, it reports benchmarks from the 50th to the 95th percentile, based on the distribution of charges or imputed allowed amounts, depending on the product line, reported on claims for services in each geozip. FAIR Health also can provide charge benchmarks from the 5th percentile to the 50th percentile. However, it should be noted that upon specific request, data can be customized to state and regional levels or configured to reflect urban/rural communities.

D. FAIR HEALTH CONSUMER TOOLS

In keeping with its commitment to transparency and its mission to provide consumers information about healthcare costs and insurance, FAIR Health has created a free consumer website and a free consumer app for mobile devices that provide reliable estimates for both out-of-network billed charges and insurers' allowed amounts for specific healthcare services and procedures in consumers' own neighborhoods. These tools also provide educational materials in consumer-friendly language on healthcare insurance and lists of resources to help consumers with healthcare and insurance issues. The consumer tools are available in English and Spanish (fairhealthconsumer.org and fairhealthconsumidor.org).

E. FAIR HEALTH DATA FOR PUBLIC PURPOSES

In furtherance of its charitable mission, FAIR Health strives to eliminate fees as a barrier for governmental and consumer use of its data. FAIR Health imposes no fee when its benchmarks are referenced in statutes or regulations as a standard for determining payments or reimbursements. In addition, FAIR Health provides its benchmarks for charges and allowed amounts free of charge to consumers on its English- and Spanish-language consumer website and app.

This submission is made by FAIR Health in accordance with its mission as a public charity to bring independent and transparent information about healthcare and insurance to all participants in the healthcare sector. FAIR Health does not represent any interested party nor does it take any position for or against any proposals.

Submitted By:

Robin Gelburd
President

FAIR Health, Inc.
530 Fifth Avenue, 18th Floor
New York, NY 10036

Tel: 212-370-0704
Fax: 917-210-3336
infor@fairhealth.org